

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-032198

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 4326

DO NOT WRITE  
ON THIS STUB

AMENDED

VS 300  
Rev. 4/59

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USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

FILED AUG 20 1963

1. PLACE OF DEATH a. COUNTY <b>JACKSON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>JACKSON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		c. CITY OR TOWN <b>KANSAS CITY</b>	
Length of stay in 1b <b>35 YEARS</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>NORTHEAST RESTAURANT</b>		d. STREET ADDRESS (If outside, give location) <b>418 So. DENVER</b>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>PEARL</b> Middle <b>M.</b> Last <b>CROWLEY</b>			4. DATE OF DEATH Month <b>AUG</b> Day <b>2</b> Year <b>1963</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11-6-1877</b>	9. AGE (last birthday) <b>85</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (City and state or country) <b>LAWSON, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>JAMES OSBORN</b>			
13b. MOTHER'S MAIDEN NAME <b>MARY PETERMAN</b>		14. NAME OF HUSBAND OR WIFE <b>THOMAS M. CROWLEY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. PAT CROWLEY</b>	
Address <b>418 So. DENVER K.C. Mo.</b>					

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral artery Thrombosis</b> <b>Cerebral artery Arteriosclerosis</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>24 h</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>6:20</b> a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Kansas City Jackson Mo</b>	20f. CITY, TOWN, OR LOCATION <b>Kansas City Jackson Mo</b>
21. I attended the deceased from <b>Jan 1 1962</b> to <b>Aug 1963</b> and last saw <b>live on July 31 1963</b> Death occurred at <b>6:20 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <b>X. L. Shireman, M.D.</b>	
22b. ADDRESS <b>4606 St John K.C. Mo</b>		22c. DATE SIGNED <b>8-2-63</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8/2/1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>1331 BRUSH CREEK K.C., Mo.</b>	23d. LOCATION (City, town, or county) (State) <b>Polo Mo.</b>
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b>		25. DATE RECD. BY LOCAL REG. <b>8-3-63</b>	
ADDRESS		26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>	

(Licensed Embalmer's Statement on Reverse Side)

Shirley  
4415 Sunnyside Ave.  
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Rollie Kessel

Licensed Embalmer No. 4690

P. O. Address Indep, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

-If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.